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ABSTRACT

Research on clients' perceptions of the acceptability of psychological treatments has grown out of concern for social validity and has resulted in the development of a hypothetical model to explain how individuals might select treatments. This model involves four components: (1) acceptability of treatment; (2) use of treatment; (3) integrity of treatment; and (4) effectiveness of treatment. Relationships among the components can best be characterized as sequential and reciprocal. To date, empirical evidence has not been amassed to support the entire model; however, researchers have provided evidence for several connections between the four components. Based on the idea that children's involvement in decisions about psychological treatments for themselves is often desirable for ethical and pragmatic reasons, this article reviews data-based research on children's judgments of the acceptability of classroom interventions for misbehaviors. Additionally, three methodological areas in treatment acceptability research are critically examined. These areas include conceptual, psychometric, and paradigmatic issues. It is concluded that a basic methodology for examining treatment acceptability has been tested and found promising. The method has aided in establishing a baseline for designing future acceptability research and has initiated a process of cataloging dimensions of interventions to which children attend when allowed to be involved in treatment decisions. (Author/RH)

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Acceptability Methodology

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Children's Acceptability of Classroom Interventions for Misbehavior: Findings and Methodological Considerations

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Running head: Children's Treatment Acceptability Research

Abstract

This article is premised on the notion that children's involvement in decisions about psychological treatments for themselves is often ethically and pragmatically desirable. Thus, the purpose of this article is to review the data-based research on children's acceptability judgments of classroom interventions and to examine critically three areas of methodology in treatment acceptability research. These methodological areas include conceptual, psychometric, and paradigmatic issues. Research on treatment acceptability has grown out of concerns for social validity and has resulted in the development of a four component, hypothetical model to explain how individuals might select treatments.

Children's Acceptability of Classroom
Interventions for Misbehavior: Findings and
Methodological Considerations

Children's involvement in making decisions about methods for changing their own behavior seems to be the exception rather than the rule. Yet, there is a growing literature which suggests involving individuals in decisions which have a direct effect on their lives usually is beneficial. Based on this literature, it has been hypothesized that involving children in setting goals and planning means for accomplishing the goals should lead to increased effort toward treatment and a reduction in resistance (e.g., Brehm, 1972; Deci, 1980).

Taylor, Adelman, and Kaser-Boyd (1983) reviewed much of the empirical literature which supports involving children in decision making. Briefly, they noted the work by De Charms (1976) in school settings which indicated programs that increased students' sense of personal control and involvement in decision making resulted in increased academic achievement and a reduction in dropout rates. A study by Lewis, Lewis, Lorimer, and Palmer (1977) found children who were allowed to make their own decisions about seeking out a school nurse showed decreased vulnerability, perceived their problems as less severe, and increased their belief in the importance of self-care. Taylor et al. (1983) queried 32 handicapped children (age range 11 to 19 years) about

involvement in planning their IEPs (Individual Educational Program). Findings from pre-IEP meeting and post-IEP meeting questionnaires indicated a high proportion of the students were interested in participating in decision-making, perceived themselves as competent to do so, and did not expect negative effects. In addition, the students followed through on a high proportion of their choices and judged their involvement effective. Only three students indicated experiencing any negative effects.

The involvement of children in decisions about psychological or educational treatments may have some risks for children. The basic argument against involving children is premised on the belief that if children are allowed to participate in treatment decisions, they may deny themselves needed interventions (Miller & Burt, 1982). Others have hypothesized that children involved in decisions concerning their own treatment may have negative experiences from information overload, dilemmas in selecting treatments, antagonism from adults who also are involved in decision making, and from knowledge of the diagnostic labels that are used to characterize their problem (Graziano & Fink, 1973; Melton, 1983; Weithorn, 1982).

If a child's involvement in the selection and design of a treatment has an important bearing on the outcome of the treatment, then as a profession it appears psychology has little empirical evidence about treatments children desire. Common sense suggests when children have a choice in selecting treatments for themselves,

they would prefer reinforcement over punishment, and when possible, they would prefer the reinforcements to be immediate and enduring and the punishments to be delayed and brief. More information about children's perspectives, however, is needed to inform treatment decisions and to understand the possible links between treatment acceptability and treatment effectiveness. Recent analogue research on "normal" children's reactions to school-based interventions has begun to provide an empirical basis for understanding the type of treatments children find acceptable when confronted with a misbehaving peer. More importantly, this treatment acceptability research has provided a methodology for examining the social validity of a wide range of treatments and issues in service delivery to children.

The purpose of this article is to review both the research findings and methods used to study children's reactions to school-based treatments for misbehaving students. Before focusing on this central purpose, the concept of social validity and a model of treatment acceptability will be discussed.

Social Validity and Treatment Acceptability

The criteria by which psychological treatments are evaluated are beginning to expand; it is no longer enough to know only that a treatment is or is not effective in changing a desired behavior. This expansion of treatment evaluation criteria can be attributed largely to the legal and consumer movements in our society. Consequently, psychologists are beginning to evaluate

the social significance of treatments (Kazdin, 1980; Strupp & Hadley, 1977; Reppucci & Sanders, 1974; Wolf, 1978). Wolf, perhaps, has done the most to highlight the importance of social judgments for psychology. He noted that society would need to validate psychological treatments on three levels: the social significance of treatment goals, the social appropriateness of the procedures, and the social importance of the effects. Collectively, these judgments are referred to as social validity.

The issue of treatment acceptability is a subset of the larger issue of social validity and has been defined by Kazdin (1981) as "judgments by laypersons, clients, and others of whether treatment procedures are appropriate, fair, and reasonable for the problem or client" (p. 493). I must acknowledge a rather complex and not well understood state of affairs in terms of a theory or model of acceptability, yet wish to suggest several factors that seem to influence an individual's judgments of treatment acceptability.

From a direct service provider's perspective (i.e., teacher, parent), initial acceptability judgments are believed to be based on one's philosophical orientation or approach to changing behavior and past experience with changing the targeted problem. Given the potential for consumer variability on dimensions of philosophical orientation and past experience, Witt and Elliott (1984) developed a model of acceptability applicable to experienced service providers. This model focuses on four elements:

acceptability of treatment, use of treatment, integrity of treatment, and effectiveness of treatment. The hypothesized relationships among these four elements can best be characterized as sequential and reciprocal. That is, acceptability is ultimately the initial issue in the sequence of treatment selection and use. Once a treatment is deemed acceptable, the probability of using the treatment is high relative to other treatments. A central element hypothesized to link use and effectiveness is treatment integrity. If integrity is high, the probability of effecting a behavioral change is enhanced. Finally, if the effectiveness of the treatment meets or exceeds the expectations of the service provider, the probability of judging the treatment acceptable is enhanced. The reaction of a recipient of the treatment toward the service provider should also influence the service provider's evaluation of the treatment. A pictorial conceptualization of this four component model of acceptability is displayed as Figure 1.

Insert Figure 1 about here

To date, empirical evidence has not been amassed to support the entire model, however, researchers have provided evidence for several of the connections between the four elements. For example, Happe (1982) has provided data concerning the acceptability-use link, Yeaton and Sechrest (1981) have provided information on the integrity-effectiveness link, and Kazdin

(1981) has investigated the effectiveness-acceptability link.

Research on the acceptability of intervention methods represents only a portion of the issues associated with social validity; however, it seems to capture the central essence of social validity. As Wolf (1978) stated, "If the participants don't like the treatment then they may avoid it, or run away, or complain loudly. And thus, society will be less likely to use our technology, no matter how potentially effective it might be" (p. 206). In effect, an unacceptable treatment may be no treatment at all!

Research on Children's Acceptability Judgements of Interventions for Misbehaviors

To date, few researchers have reported investigating the acceptability of interventions from a child's perspective. Notable exceptions include treatment studies by Foxx and Jones (1978), Ollendick, Matson, Esveltd-Dawson, and Shapiro (1980), and Kirigin, Braukmann, Atwater, and Wolf (1982) where anecdotal information was collected about clients' satisfaction with a treatment. Kazdin, French, and Sherick (1981) have assessed children's acceptability of psychological treatments more directly using the Treatment Evaluation Inventory (TEI), a 15-item rating scale. The Kazdin et al. (1981) investigation was an analogue study of how child psychiatric inpatients, their parents, and the institutional staff rated the acceptability of four treatments (i.e., positive reinforcement of incompatible behavior, positive practice, medication, and time out from reinforcement) for children

with severe behavior problems. The relative ratings of acceptability for the four treatments were identical for children, parents, and staff, although children rated all treatments as less acceptable than did parents or staff members. Specifically, reinforcement of incompatible behavior was evaluated as the most acceptable treatment for a child displaying a severe behavior problem. Positive practice, medication, and time out from reinforcement followed reinforcement of incompatible behavior in terms of acceptability ratings. A secondary, but interesting finding was that children above 10 years of age rated treatments significantly more acceptable than did children below 10 years of age.

Elliott, Witt, Galvin, and Moe (1984) investigated normal sixth-grade children's reactions to 12 interventions for classroom misbehaviors involving a male student who either destroyed another student's property or frequently talked out of turn. The students' acceptability ratings were documented via the Children's Intervention Rating Profile or CIRP (Witt & Elliott, 1984), a seven-item, one-factor scale (see Table 1). The alternative treatments

Insert Table 1 about here

which were rated by 79 sixth graders were: private reprimand by teacher, public reprimand by teacher, private praise by teacher, public praise by teacher, individual loses recess, individual

extra recess, whole class loses recess, whole class extra recess, individual stays in for recess, individual goes to a quiet room, individual goes to principal's office, and individual earns rewards via a point system. These 12 treatments were classified either as a verbal, a reinforcement, or a traditional intervention and were designed to vary on dimensions of individual-group and positive reinforcement-negative reinforcement. Elliott and his associates found sixth graders rated the acceptability of the 12 interventions very differently. Specifically, interventions that emphasized individual teacher-student interactions, or group reinforcement, or negative sanctions for the misbehaving child were rated as most acceptable. Public reprimands of an individual and negative contingencies for a group when only one child misbehaved were rated as unacceptable interventions by sixth graders. The four traditional interventions (i.e., principal's office, point system, staying in during recess, quiet room) as a group were rated the most acceptable methods when compared to the more behavioral interventions in the study. A final finding by Elliott et al. (1984) was that behavior problem severity did not significantly impact sixth-grade students' ratings of interventions except for the traditional interventions.

Following the Elliott et al. (1984) study, Turco and Elliott (1984) investigated the influence of children's developmental level and sex on their acceptability ratings of interventions. These researchers had 693 fifth-, seventh-, and ninth-grade

students complete the CIRP in response to 12 intervention methods to correct classroom behavior problems. Results of a factorial analysis of variance indicated significant main and interaction effects for: intervention method; rater's sex and grade; intervention method and grade; and intervention method, grade, and problem severity. Further analyses were undertaken to identify the intervention preferences of students at each grade level. In general, students at all three grades rated home-based interventions as the most acceptable method and rated public reprimand as an unacceptable method for changing another student's behavior. The responses to the other interventions were quite variable across grades. For example, fifth graders rated both private and public praise as highly acceptable methods for changing behavior, but seventh and ninth graders both rated private praise as an unacceptable method. Self-monitoring is thought to be more desirable for older than younger children, yet only fifth graders rated it an acceptable treatment. Loss of free time or recess was evaluated as an unacceptable method for changing behavior by the fifth graders, but was rated as very acceptable by both the seventh and ninth graders. Only ninth graders indicated a sensitivity to selecting intervention methods based upon the severity of the problem and the sex of the respondent. The researchers concluded that caution is warranted when making generalizations about the acceptability of various intervention methods given the influence of grade, sex, and problem severity

on acceptability ratings.

Given the perceived popularity of group contingency interventions among teachers and children's differential acceptability responses to group contingency methods (see Elliott, Witt, Galvin, & Moe, 1984; Turco & Elliott, 1984), a more detailed investigation was undertaken by Elliott, Turco, Evans and Gresham (1984) of various types of group contingency methods. Litlow and Pumroy (1975) classified group contingency systems into one of three categories: interdependent, dependent, or independent. (In an interdependent group contingency, the same response requirements are in effect for the entire group and reinforcement is contingent upon the group performance level. In a dependent group contingency, reward for a group is based on the performances of selected class members. Independent contingency systems base reinforcement on each member's own performance.) Elliott, Turco, Evans, and Gresham (1984) investigated the acceptability of these three categories of group contingency methods as a function of the severity of a classroom behavior problem. A sample of 660 black and white, male and female, fifth graders responded via the CIRP to one of three problem severities (i.e., two children being disruptive, half a class being disruptive, a whole class being disruptive) and one of the three group contingency methods. Significant results were observed for interactions between rater's sex and problem behavior severity and rater's race and problem behavior severity. The major new

findings of this study of treatment acceptability were: (a) female students rated the three forms of group contingency interventions less acceptable than males as the severity of the problem increased, (b) black students, in general, rated group contingency interventions significantly more acceptable than white students, and (c) the three forms of group contingency interventions were all rated acceptable in an absolute sense and were not rated significantly different. These findings highlight the impact of two basic individual differences, race and sex, on children's acceptability judgments of interventions, as well as reinforce a common perception that group contingency interventions are generally acceptable to children.

A study of preschool children's and their parents' choices of disciplinary actions (Wolfe, Katell, & Drabman, 1982), although not centrally concerned with treatment acceptability, provides additional information about young children's involvement in selecting treatments. Specifically, Wolfe and his associates showed 40 preschoolers videotapes containing six brief scenes depicting common parent-child conflicts (e.g., child refused to eat supper, played with food, and ignored father's commands). The children were asked to tell an experimenter what they would do if they were the parent on the tape, and what their own parents would do if this happened at home. In addition, 15 mothers of children were selected randomly to view the same scenes and to indicate their choice of disciplinary actions. Responses

of parents and children were coded as verbal coercion, physical coercion, or no coercion. Results of this analogue study indicated preschoolers choose disciplinary actions in accordance with their perceptions of their parents' manner of dealing with the same situation. There was a high congruence between parent and child on consequences for discipline. Based on intra-individual findings across the six conflict situations, the researchers concluded the preschoolers were responding to the conflict situations according to situation-specific cues. For example, scenes involving loud arguments and overt noncompliance on the part of the child were more likely to result in coercive solutions than those scenes in which less oppositional behavior was displayed.

Summary and Conclusions About Acceptability Research With Children

An integration of the research findings concerning children's acceptability judgments of interventions, at this time, does not allow for the extraction of principles of human behavior or the identification of a most preferred intervention; however, under the constraints of the research methodology (which are considerable), one can offer the following guidelines: (a) children differentially evaluate the acceptability of interventions with younger children preferring positive interventions and/or the interventions modeled by adults in their environment and older children rating more adverse and/or non-traditional interventions as acceptable; (b) children's sex and racial-ethnic background seem to affect intervention acceptability ratings

differentially; and (c) the severity of the target problem is generally not a factor for the younger children investigated, but does influence adolescents' acceptability ratings. These conclusions are subject to further investigation and under varying methodologies. Several methodological issues in the previously reviewed acceptability research are discussed in the next section.

Methodological Issues in Treatment Acceptability Research

Methodological issues in treatment acceptability research can be classified into three areas: conceptual, psychometric, and paradigmatic. Each of these areas will be discussed briefly and suggestions for further research identified.

Conceptual Issues

The major conceptual issue that has occurred in the research on children's acceptability of interventions involves the meaning of acceptability. The concept of acceptability has been operationalized via the development of rating scales. Items on these scales (i.e., CIRP and TEI) use terms such as "fair" and "like" and statements such as "would help this child" and "too harsh" to elicit reactions that collectively are labeled acceptability. Whether adult notions of acceptability match those of children's requires further examination with consideration for developmental differences due to cognitive ability and moral development. For example, what acceptability means to a young, adult-dependent children and a peer-oriented adolescent may be very different.

The conceptual issue of the meaning of acceptability also requires some knowledge of respondents learning history with a given treatment. Such knowledge may help tease apart reactions that differentiate acceptability from consumer satisfaction.

Future research that documents respondents' prior experiences with the treatments of interest and also evaluates respondents' cognitive abilities with respect to moral development may contribute valuable information toward the resolution of the meaning of acceptability. The use of adjective checklists (see Kazdin, 1981), such as the Semantic Differential (Osgood, Suci, & Tannebaum, 1957), may also be helpful in further understanding what the concept of acceptability means to children.

Psychometric Issues

To date, two experimental rating scales have been developed to assess children's reactions concerning the acceptability of a given treatment. Kazdin, French, Sherick (1981) modified the TEI for children. The TEI consists of 15 items in a Likert-type format (1- to 7-point scale where 1 = not at all and 7 = very much). Kazdin (1980) reported that items were selected from a pool of 45 items based on factor analyses replicated across four separate samples and from experimental work showing the measure to discriminate alternative treatments. The child version of the TEI consists of the same items as the adult version with language changes to facilitate comprehension and a 3-point response scale instead of the more complex 7-point scale. The child

3-point scale corresponds exactly to the three major points on the adult 7-point scale (i.e., 1 = not at all, 2 = moderate, and 3 = very much) so that total scores were comparable in meaning. No reliability or validity information is reported for the child version of the TEI.

The CIRP developed by Witt and Elliott (1984) was influenced in content and form by the Intervention Rating Profile or IRP (Witt & Martens, 1983), but is not simply a downward revision. The CIRP is a seven-item, one-factor scale written at a fifth-grade readability level. The CIRP has a coefficient alpha of .89. No concurrent or predictive validity data have been amassed at this time. The CIRP has been used with over 1,000 children ranging in ages between 10 and 15. Examination of CIRP protocols indicates infrequent failures to response and no evidence of response set.

The CIRP and TEI appear to be reasonable methods for collecting data on students' reactions to a treatment for a given behavior problem. Discriminant and convergent validity data with other attitudinal measures concerning psychological treatments would be valuable and is the next logical step in the development of these scales. Such data would also contribute to the further refinement of the concept of acceptability. In addition, data on using the CIRP via an interview format as compared to an individual paper-and-pencil format may provide for more efficient use with a younger population, as well as individual clinical

cases.

Paradigmatic Issues

Research on children's acceptability of psychological treatments predominantly has been analogue in nature and designed in a problem-solution-evaluation vignette format. Such a research paradigm presents several concerns. First, the cognitive demands of the task necessitate means-end thinking and may be beyond many children until adolescence. If this is accurate, the consequence is that children may simply react only to the solution (i.e., treatment method). Developmental data lends credence to this hypothesis in that only ninth graders' acceptability ratings were differentially influenced by the severity of the problem presented (Turco & Elliott, 1984).

A second issue concerns the perspective the rater is taking with the problem-solution method of presenting a problem behavior. The instructions encourage a student to rate a treatment method for the given problem behavior. It is assumed this instruction elicits responses indicative of the method the student rater would want applied to himself or herself if they misbehaved. At this time, this assumption concerning the perspective of the rater is just that, an assumption.

A final paradigmatic issue concerns the mode of presenting information. Kazdin has utilized an audiotape to present children a problem and a treatment, whereas Elliott and his associates have used only written case studies. The ecological validity

and meaningfulness of the communication of both the written and audiotape modalities is a concern. Research by Martens, Witt, Elliott, and Darveaux (in press) tested, among other variables, the difference between videotaped versus written problem statements. This study was done with teachers who rated the acceptability of several school-based interventions. The mode of presentation did not significantly influence the teachers' acceptability ratings of interventions. Whether this finding will generalize to children is an empirical question. Clearly, videotaped behavior problem vignettes would provide a richer stimulus and given the possible influence of variables such as race, sex, and physical stature on the selection of interventions, it seems a logical avenue to extend the research on treatment acceptability.

Conclusions

In this article, I have discussed the substantive literature which suggests children's involvement in treatment decisions is theoretically and ethically desirable, reviewed the data-based research on children's acceptability judgements of interventions, and critically examined three areas of methodological concern for treatment acceptability research. At this point in the research, one can conclude that a basic methodology for examining treatment acceptability has been tested and found promising. This method has aided in establishing a baseline for designing future acceptability research and has initiated a process of cataloging dimensions of interventions that children attend

to when allowed to be involved in treatment decisions. Future research that directly links the acceptability variable to treatment efficacy will provide the validity that psychology and society desires.

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Table 1

The Children's Intervention Rating Profile^a

	I agree	I do not agree
1. The method used to deal with the behavior problem was fair	+-----+-----+-----+-----+	+-----+-----+-----+-----+
2. This child's teacher was too harsh on him.	+-----+-----+-----+-----+	+-----+-----+-----+-----+
3. The method used to deal with the behavior may cause problems with this child's friends.	+-----+-----+-----+-----+	+-----+-----+-----+-----+
4. There are better ways to handle this child's problem than the one described here.	+-----+-----+-----+-----+	+-----+-----+-----+-----+
5. The method used by this teacher would be a good one to use with other children.	+-----+-----+-----+-----+	+-----+-----+-----+-----+
6. I like the method used for this child's behavior problem.....	+-----+-----+-----+-----+	+-----+-----+-----+-----+
7. I think that the method used for this problem would help this child do better in school.....	+-----+-----+-----+-----+	+-----+-----+-----+-----+

^aDeveloped by Witt and Elliott (1983).

Figure Caption

Figure 1. Hypothetical model of factors that influence treatment acceptability.

